| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155582 | A. BUILDING 00<br>B. WING | 05/04/2012 |

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| F0000 | The visit was for a Recertification and State Licensure Survey.<br><br>Survey dates:<br>April 30, May 1, 2, 3, & 4, 2012<br><br>Facility number: 000521<br>Provider number: 155582<br>AIM number: 100266980<br><br>Survey team:<br>Shelly Vice RN, TC<br>Carol Miller RN<br>Honey Kuhn RN<br>(5/1, 5/2, 5/3, 5/4, 2012)<br><br>Census bed type:<br>SNF: 9<br>SNF/NF: 107<br>Total: 116<br><br>Census payor type:<br>Medicare: 12<br>Medicaid: 82<br>Other: 22<br>Total: 116<br><br>Sample: 24<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | Quality review 5/14/12 by Suzanne Williams, RN | | | |

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| F0253 SS=B | 483.15(h)(2)<br>HOUSEKEEPING & MAINTENANCE SERVICES<br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br>Based on observation and interview, the facility failed to maintain a clean environment as evidenced by dirt and debris between the floor and the cove base along the entrance to and the perimeter of the pod area which circled the lounge of the Sunshine Unit. This finding had the potential to effect 22 of 22 residents who resided on the Sunshine Unit of 116 residents in the facility.<br><br>Finding includes:<br><br>The Environmental tour, while accompanied by the Maintenance Director, was completed on 05/03/12 between 8:45 a.m. and 10:00 a.m. The facility consists of six resident "pods", five which are carpeted, including the baseboard area. The sixth pod, "Sunshine", contained tiled flooring with covebase. Upon entrance to the Sunshine Pod, dirt and debris were noted between the cove base and the tiled floor along the entire perimeter of the pod.<br><br>Interview with the Maintenance Director, at the time, indicated the unit was mopped daily and the floors buffed weekly. The | F0253 | Miller's Merry Manor of Wakarusa respectfully requests consideration for Paper Compliance for this Plan of Correction due to the low number of deficiencies & scope/severity related to this annual survey.It is the policy of the Miller's Merry Manor of Wakarusa to provide a clean & comfortable environment for all residents & visitors. No residents were adversely affected by this deficiency. All residents residing on the Sunshine pod could have been potentially affected by this deficiency. In the future, the Sunshine pod corridor/lounge baseboard will be thoroughly cleaned on a monthly basis. The Sunshine pod corridor/lounge area has been added to the "Baseboard Cleaning" schedule (Attachment A). All housekeeping staff will be inserviced regarding the need to thoroughly clean the Sunshine pod corridor/lounge baseboard on or before 6/3/12. Furthermore, the "Housekeeping Services Review" QA tool (Attachment B) will be utilized to monitor the cleaning of the Sunshine pod corridor/lounge baseboard on a monthly basis and any concerns will be addressed immediately. The Housekeeping Services | 06/03/2012 |

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| | Maintenance Director ran his finger along the area between the cove base and the floor, identifying the brown/black substance as a buildup of dirt, dust & debris. The Maintenance Director indicated the affected area should be cleaned routinely with a brush. The Maintenance Director indicated the facility had no policy & procedure in regard to the cleaning of the area.<br><br>3.1-19(f) | | Review QA tool will be reviewed on a quarterly basis as part of the facility Quality Assurance program & the Envrionmental Services Supervisor, or designee, will be responsible to ensure completion ongoing. | |

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| F0441<br>SS=E | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>Based on observations, record reviews and interviews, the facility failed to | F0441 | It is the policy of Miller's Merry Manor of Wakarusa to maintain | 06/03/2012 |

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| | ensure staff washed their hands when necessary during medication administration for 1 of 4 residents observed during medication pass (Resident #85), and failed to ensure the appropriate use of sanitizing hand gels while assisting residents with meals in the dining room, potentially affecting 70 residents who receive their meals in the dining room of 116 residents in the facility.<br><br>Findings include:<br><br>1. On 4/30/12 at 12:30 p.m., observations were made during the noontime lunch in the dining room area. The staff assisting with the serving and feeding of the residents were observed to be using a sanitizing hand gel for infection control means. The gels being used by the staff helping with the residents requiring assistance with their actually feeding, were individual plastic bottles with plastic flip tops being stored within their individual pants/tops pockets.<br><br>On 4/30/12 at 12:30 p.m. an observation was made of a wall hand gel sanitizer dispenser to be located at the kitchen-dining room serving window for infection control means. An observation was made of staff assisting with the serving during the lunch time period to be | | an infection control program that is designed to provide a safe, sanitary, & comfortable environment to help prevent the development & transmission of disease & infection. Resident #85 was not adversely affected by this deficiency. All residents could have been potentially affected by this deficiency. Infection control practices will be maintained when completing medication administration. RN #5 has been inserviced 1:1 regarding the facility medication administration policy/procedure. The "Hand Washing/Hand Asepsis Policy" (Attachment C) has been updated to include the use of alcohol gel as an infection control intervention. Staff will not handle food with their bare hands during meal times while assisting to prepare/set up resident meal trays. Gloves will be used by staff if there is a future need to handle food items & hands will be washed per facility policy/procedure following the removal of gloves. The Director of Nursing will provide inservice education to all licensed nursing staff on or before 6/3/12 regarding the policy/procedure for "Medication Administration Procedure" (Attachment D) which includes parameters for proper hand washing. An all staff inservice will be held on or before 6/3/12 to review the facility "Hand Washing/Hand Asepsis Policy" (Attachment C) & all staff will | |

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| | actively pressing the dispenser of the wall hand gel sanitizer between trays being taken from the service window.<br><br>On 4/30/12 at 12:30 p.m., staff assisting with the trays were observed to be holding food products in their hands to aid in feeding and the preparation of the food for consumption by the residents.<br><br>On 4/30/12 at 3:10 p.m. an interview was conducted with the Infection Control Nurse. It was stated during the interview that one way the facility prevented the direct transmission of germs was to use an alcohol-based antiseptic hand gel.<br><br>On 4/30/12 at 5:00 p.m., staff assisting with the trays were observed to be using the wall hand sanitizers between trays and helping residents prepare their foods.<br><br>On 5/1/12 at 8:00 a.m. observations were made during the breakfast times in the main dining room area and on the Rehab, Sunshine and Rose units. The staff were observed to be using the individual hand sanitizing gels between residents. This use was noticed to be while assisting them with their actual food preparation including touching the food products with their hands.<br><br>On 5/1/12 at 10:20 a.m. an observation | | participate in a return demonstration of the proper hand washing technique (Attachment E). An emphasis on infection control measures while handling resident food will be reviewed. Staff will be instructed to utilize gloves whenever directly handling food products or to use utensils to manipulate/prepare food for resident consumption during meals. The use of alcohol gel to sanitize hands will be used per facility policy/procedure when staff are in the dining room. The Inservice Director, or designee, will be responsible to complete the "Medication Administration Procedure" (Attachment D) QA tool with all newly hired licensed staff & quarterly with all nurses to monitor hand washing & compliance ongoing. Any identified trends will be reviewed immediately with staff members as need be & will be corrected accordingly. The facility Nurse Managers & Dietary Manager will participate in routine walking rounds of the dining rooms to monitor for proper hand washing, use of gloves or utensils to prepare/manipulate resident food at meal times & during medication administration observing for compliance.The Inservice Director, or designee, will be responsible to complete the "Infection Control Review" QA tool (Attachment F) 3 times per week for 2 weeks, then weekly for | |

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| | was made of a staff member giving a sugar cookie to Resident #92 after using hand sanitizing gel on her own hands.<br><br>On 5/1/12 at 10:25 a.m. an interview was conducted with the DNS (Director of Nursing Services). The policy/ procedure for handwashing was reviewed in their presence. The policy was titled, "Subject: Hand Washing and Hand Asepsis."<br>"5. Alcohol-Based antiseptic cleanser should not be used around food or food products. Hands should be washed with soap and water during meal service if there is direct hands-on contact with resident(s). There is no need to wash hands from tray to tray with simple delivery of food and eating utensils."<br><br>On 5/1/12 at 12:30 p.m. observations were made during the lunchtime dining hour of the staff assisting with resident meals. It was noted that staff were using the wall dispenser and individual flip top bottles of the alcohol based hand gels. Staff were observed to be directly touching food items with their hands. There were no gloves observed. There was no handwashing observed.<br><br>On 5/2/12 at 8:30 a.m. observations were made during the breakfast dining hour of staff assisting with resident meals. Staff were observed to be using the dispenser | | 4 weeks, then monthly thereafter to monitor continued compliance ongoing. Any identified trends or findings will be logged on a QA log & reviewed during the monthly facility Quality Assurance meeting. | |

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| | and individual flip top bottles of the alcohol based hand gels. Staff were observed to be directly touching food items with their hands. There were no gloves being used and/or handwashing being noted.<br><br>On 5/3/12 at 8:30 a.m. observations were made during the breakfast dining hour of staff assisting with resident meals. It was noted that staff were using the wall dispenser and the individual flip top bottles of the alcohol based hand gels. Staff were directly touching food items with their hands and not wearing gloves or washing their hands.<br><br>On 5/3/12 at 12:55 p.m. an interview was conducted with the DNS about the Handwashing Policy and Procedure and the observations made of the dining room areas. The DNS indicated, "...it sure does say that..." in regard to the use of alcohol based hand gels around food.<br><br>On 5/3/12 at 5:30 p.m. an observation was made during the dinner hour of the staff assisting with the resident meals. It was noted that staff were using the dispenser and individual bottles of the alcohol based hand gels. Staff were observed to be directly touching food items with their hands. There were no gloves being used and/or handwashing | | | |

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| | being done.<br><br>2. On 4/30/12 at 5:05 p.m. an observation was made of RN #5 during medication administration pass for Resident #85. The RN prepared the medications as prescribed. The RN left the medication cart, entered a separate resident's private bathroom, turned the bathroom handle on to access "tap water." RN #5 indicated, "(Resident #85's name) doesn't like ice cold water. I add tap water to her Pro Stat or she won't drink it at all... I know she likes it...." RN#5 filled the Dixie-type medication drinking cup with tap-water, then turned off the bathroom faucet and returned to her medication cart to administer the medication to Resident #5. RN #5 did not wear gloves or wash her hands after touching the faucet.<br><br>On 4/30/12 at 5:10 p.m. an interview was conducted with RN #5. When questioned about the handwashing policy/procedure of not washing hands after touching/ using the resident's bathroom and not wearing gloves, RN #5 stated, "...I should've washed my hands, shouldn't I ...."<br><br>On 5/1/12 at 10:25 a.m. an interview was conducted with the DNS. The policy/procedure for handwashing was reviewed in their presence. The policy | | | |

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| | was titled, "Subject: Hand Washing and Hand Asepsis." #3 of the Procedure stated:<br>"3. Key Procedural Points: A. Specific times hands must be washed: ... IV. Before and after using the restroom...."<br><br>3.1-18(l) | | | |

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| F0514 SS=A | 483.75(l)(1)<br>RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>Based on observation, record reviews and interviews, the facility failed to ensure documentation of medication administration was accurate for 3 of 4 residents observed during medication administration. (Residents #95, #10 and #85).<br><br>Findings include:<br><br>On 4/30/12 at 4:30 p.m. an observation was made of Resident #95's 5:00 pm medication administration pass. It was noted that RN #3 documented their initials on the administration record prior to administering the medications.<br><br>On 4/30/12 at 4:32 p.m. an interview was conducted with RN #3. It was noted by RN #3, "..this is the way I always do it...." | F0514 | It is the policy of Miller's Merry Manor- Wakarusa to maintain clinical records on each resident in accordance with accepted professional standard practices that are complete, accurately documented, readily accessible, & systemically organized.<br>Residents #95, #85, & #10 were not adversely affected by this deficiency. All residents could have been potentially affected by this deficiency. All charge nurses observed signing the MAR prior to administering medications to residents #95, #85, & #10 received 1:1 inservicing on proper documentation of medication administration according to facility policy. An inservice for all licensed nursing staff will be held on or before 6/3/12. The importance of accurate, organized, & complete documentation will be reviewed. The licensed nurses will be | 06/03/2012 |

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| | On 4/30/12 at 4:40 p.m. an observation was made of Resident #10's 5:00 pm medication administration pass. It was noted that RN #4 documented their pintails on the administration record prior to administering the medications.<br><br>On 4/30/12 at 4:42 p.m. an interview was conducted with RN #4. It was noted by RN #4, "... yes, this is the way I always do this..."<br><br>On 4/30/12 at 4:45 p.m. an observation was made of Resident #85's 5:00 pm medication administration pass. It was noted that RN #5 documented their pintails on the administration record prior to administering the medications.<br><br>On 4/30/12 at 4:48 p.m. an interview was conducted with RN #5. It was noted by RN #5, "... I think so... I usually do it just like this..."<br><br>On 5/1/12 at 9:50 a.m. an interview was conducted with LPN #6. It was noted by LPN #6, "... absolutely... I was trained this way ... I never document a medication before administering the medicine. It is our policy..."<br><br>On 5/1/12 at 10:15 a.m. an interview was conducted with the Director of Nursing Service (DNS). It was noted the policy | | instructed on the importance of signing medications out on the MAR only after the medication has been administered or offered & will be responsible to follow the facility policy for "Medication Administration Procedure" (Attachment D). The Inservice Director, or other designee, will be responsible to ensure that this policy is reviewed with all licensed nurses, including any newly hired licensed nurses, with their signature acknowledging their understanding of this policy, on a quarterly basis to monitor for compliance ongoing. Any findings will be recorded on a facility QA log & the Inservice Director, or other designee, will be responsible to provide ongoing inservicing as needed on a 1:1 basis for any identified documentation issues to ensure compliance ongoing. Furthermore, QA logs are reviewed monthly during facility Quality Assurance meeting to monitor compliance ongoing. | |

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| MILLER'S MERRY MANOR | 300 N WASHINGTON ST<br>WAKARUSA, IN 46573 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | and procedure for medication administration was to document after administering medications.<br><br>On 5/1/12 at 10:15 a.m., the Policy and Procedure titled, "Subject: Medication Administration Procedure: Administering Oral Medications" was reviewed. It was noted for documentation to be completed after medicine had been administered.<br><br>3.1-50(a)(2) | | | |